



# HIGH MOUNTAIN HEALTH, P.A. Patient Registration Form

Referred by: \_\_\_\_\_

Name: \_\_\_\_\_ S.S. Number: \_\_\_\_\_

Address: \_\_\_\_\_ Date of birth: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Gender: \_\_\_ Male \_\_\_ Female Marital status: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone No. \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone No. \_\_\_\_\_

Emp. Address: \_\_\_\_\_ City/State: \_\_\_\_\_

Patient's Occupation: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Secondary Insurer: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

### AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize High Mountain Health, PA, to apply for benefits on my behalf for covered services rendered by my family physician or by his/her order. I request that payment from my insurance company be made directly to High Mountain Health, PA (or to the party who accepts assignment),

I certify that the information I have reported with regard to my insurance coverage is correct. I agree and accept the terms of the High Mountain Health's Financial Policy.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing,

Date: \_\_\_\_\_ Signature (Patient/Guardian) \_\_\_\_\_